Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Aging and Disability Services Administration
AND
Medical Assistance Administration

Nursing Facilities

Billing Instructions

[Chapter 388-96 WAC]

About this publication

This billing instruction is designed to help nursing facility providers and their staff understand the Aging and Disability Services Administration's (ADSA) and the Medical Assistance Administration's (MAA) regulations and requirements necessary for reporting accurate and complete claim information. Refer to Chapter 74.46 RCW (Nursing Facility Medicaid Payment System) and 71A RCW (Developmental Disabilities) for further information.

This publication supersedes all previous ADSA/MAA Nursing Facilities Billing Instructions.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services

Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

How can I get MAA's provider issuances?

To obtain MAA's provider numbered memoranda and billing instructions, go to MAA's website at http://maa.dshs.wa.gov (click on the ***Billing Instructions/Numbered Memoranda*** or ***Provider Publications/Fee Schedules*** **link**).

To request a free paper copy from the Department of Printing:

1. **Go to: http://www.prt.wa.gov/** (Orders filled daily.)

   a) Click ***General Store***.

   b) If a **Security Alert** screen is displayed, click **OK.**

      i. Select either ***I'm New*** or ***Been Here***.
      ii. If new, fill out the registration and click ***Register***.
      iii. If returning, type your email and password and then click ***Login***.

   c) At the **Store Lobby** screen, click ***Shop by Agency***. Select ***Department of Social and Health Services*** and then select ***Medical Assistance.***

   d) Select ***Billing Instructions, Forms, Healthy Options, Numbered Memo, Publications,*** or ***Issuance Correction***. You will then need to select a year and the select the item by number and title.

2. **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX (360) 586-6361/ telephone (360) 586-6360. (Orders may take up to 2 weeks to fill.)

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs; however, MAA's response is based solely on the information provided to the [MAA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs.
[WAC 388-502-0020 (2)].

Where do I call for information to become a DSHS provider, to submit a change of address or ownership, or to ask questions about the status of a provider application?

Aging and Disability Services Administration
(800) 422-3263

Where do I send my hardcopy claims?

Division of Program Support
PO Box 9248
Olympia, WA 98507-9248

How do I obtain copies of billing instructions or numbered memoranda?

Go to MAA's web site at: http://maa.dshs.wa.gov, Provider Publications/Fee Schedules link.

Who do I contact if I have questions regarding…

Policy, payments, denials, general questions regarding claims processing, or to request billing instructions?

Claims Processing Nursing Facility Case Load* Managers:

A-C	(360) 725-2133
D-G	(360) 725-1115
H-L	(360) 725-1052
M-O	(360) 725-1158
P	(360) 725-1051
Q, R, T-Z	(360) 725-1054
S	(360) 725-1282

*Case loads are based on the first letter of your nursing facility provider name.

What is included in the nursing facility per diem or general rate questions?

Aging and Disability Services Administration
(800) 422-3263

Private insurance or third-party liability?

Coordination of Benefits Section
(800) 562-6136

Electronic Claims Submission Information?

Affiliated Computer Services (ACS) Hotline for technical testing questions on software or ACS EDI GATEWAY services:

(800) 833-2051

ACS EDI Gateway Inc., web page

http://www.acs-gcro.com

DSHS HIPAA web site for free software and HIPAA-compliance information:

http://maa.dshs.wa.gov/dshshipaa

Federal HIPAA-compliance web site with practical advice for providers and the answers to frequently-asked questions (FAQ):

http://www.cms.gov/hipaa

How do I obtain DSHS forms?

To **download** DSHS forms, visit DSHS Forms and Records Management Service on the web:
http://www1.dshs.wa.gov/msa/forms/eforms.html

To **have a paper copy sent** to you, contact DSHS Forms and Records Management Service:
Phone: (360) 664-6047
Fax: (360) 664-6186

Include in your request:

- Form number and name;
- Quantity you want;
- Your name;
- Your office/organization name; and
- Your complete mailing address.

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Definitions

This section defines terms and acronyms used within these billing instructions.

Aging and Disability Services Administration (ADSA) - As a component of the Washington State Department of Social and Health Services, ADSA provides a broad range of social and health services to adult and older persons living in the community and in residential care settings. These services are designed to establish and maintain a comprehensive and coordinated service delivery system which enables persons served to achieve the maximum degree of independence and dignity of which they are capable.

By Report (BR) – A method of reimbursement in which MAA determines the amount it will pay for a service that is not included in MAA's published fee schedules. MAA may request the provider to submit a "report" describing the nature, extent, time, effort, and/or equipment necessary to deliver the service. [WAC 388-531-0050]

Chart – A summary of medical records on the individual patient.

Client - An individual who has been determined eligible to receive medical or health care services under any MAA program.

Code of Federal Regulations (CFR) - Rules adopted by the federal government.

Community Services Office (CSO) - An office of the department's economic services administration that administers social and health services programs at the community level.

Department - The state Department of Social and Health Services (DSHS).

Division of Developmental Disabilities (DDD) - The division in DSHS responsible for administering and overseeing services for clients with developmental disabilities.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Home and Community Services (HCS) - This division promotes, plans, develops, and provides long-term care services responsive to the needs of persons with disabilities and the elderly with priority attention to low-income individuals and families. They assist people with disabilities and their families obtain appropriate quality services to maximize independence, dignity, and quality of life.

Hospital – A facility licensed under chapter 70.41 RCW, or comparable health care facility operated by the federal government or located and licensed in another state.

Institutional Award Letter - An official document issued by the local DSHS Home and Community Services (HCS) office or Community Services Office (CSO) which provides information about a nursing facility resident. The information pertains to the MAA client's income and resources, their medical care eligibility, the effective date for care, the care level, Medicare status, etc.

Intermediate/Mental Retardation Facility (IMR) - An IMR facility for DDD is defined as a Title XIX-certified intermediate care facility for persons with mental retardation. These facilities:

- Provide IMR services to eligible clients with mental retardation or related conditions who require intensive habilitation training;
- Provide support services which may best be provided in a 24-hour residential care facility; and
- Meet the standards and guidelines of the federal nursing facility IMR program.

Managed Care – A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Maximum Allowable - The maximum dollar amount for which a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Nursing Facility (NF) - A home, place, or institution, licensed under chapter 18.51 or 70.41, RCW, where skilled nursing care services are delivered. [WAC 388-96-010]

Nursing Facility Rates For ADSA Payment - Prospective reimbursement rates as outlined in WAC 388-96-704.

Patient Identification Code (PIC) - An alphanumeric code which is assigned to each Medicaid client and which consists of:

a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tiebreaker).

Per Diem Costs - (Per patient day or per resident day) Total allowable costs for a fiscal period divided by total patient or resident days for the same period. [WAC 388-96-010]

Provider or Provider of Service – An institution, agency, or person:

- Who has a signed agreement (Core Provider Agreement) with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department.

Record – Dated reports supporting claims submitted to the MAA for medical services provided in a client's home, a physician's office, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of services must be in chronological order by the practitioner who provided the service.

Remittance and Status Report (RA) - A report produced by Medicaid Management Information System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions.

Resident - A person residing in a nursing facility. The term resident excludes outpatients and persons receiving adult day or night care, or respite care.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Usual and Customary Charge - The fee that the provider typically charges the general public for the product or service.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

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Nursing Facilities

About the Program

The purpose of the Nursing Facilities program is to reimburse for medically necessary nursing facility services provided to Medicaid-eligible clients. The nursing facility billing process for DSHS clients was developed by the Aging and Disability Services Administration (ADSA) and the Medical Assistance Administration (MAA). Refer to Chapter 74.46 RCW (Nursing Facility Medicaid Payment System) and 71A RCW (Developmental Disabilities) for further information.

Client Eligibility

Who is eligible for nursing facility services?

Clients who qualify for benefits under Chapter 388-513 WAC will be issued an Institutional Benefits Award Letter by a HCS office (or the CSO for short stays in a nursing facility – less than 30 days). This award letter qualifies the client for nursing facility services.

Hospice Clients Who Are Nursing Facility Residents

For information on hospice clients residing in a nursing facility, refer to MAA's current *Hospice Program Billing Instructions* (see **Important Contacts** section to see how to obtain MAA's billing instructions).

Reimbursement

MAA reimburses nursing facilities for costs that are ordinary, necessary, related to the care of medical care recipients, and not expressly unallowable. [RCW 74.46.190 (2)] Refer to RCW 74.46.410 and WAC 388-96-585 for examples of unallowable costs.

Notifying Clients of Their Rights to Make Their Own Healthcare Decisions (Advance Directives) [42 CFR, Subpart I]

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give ***all adult clients*** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Nursing Facility Codes

Patient Class

Enter Value Code 24 with the appropriate Patient Class Code (see table below) in form locator 39-41 on the UB-92 claim form.

Patient Class Code
20: SNF
23: IMR-title XIX Elig
24: Dual Medicare/Medicaid
26: Swing Bed
27: IMR-noneligible for title XIX
29: Full Medicare
40: Exceptional Therapy Care
50: Behavioral support
60: Community Home Project

Revenue Code

Bill nursing facility claims using revenue code **0190** (Subacute Care General Classification) in form locator 42 on the UB-92 claim form.

Patient Status Codes

MAA is now using CMS patient status codes instead of the previous turnaround document (TAD) discharge codes (see table below). Enter the appropriate Patient Status Code in form locator 22 on the UB-92 claim form.

TAD Discharge Code	CMS Patient Status Code
1: To hospital	**02:** To hospital
2: To another nursing facility	**03:** To skilled nursing facility
4: Deceased	**20:** Expired (also use when a patient is admitted and dies on the same day)
5: Private pay, hospice, home, or social leave	**01:** Home
	50: Hospice/home
	51: Hospice/medical facility
6: Still a patient	**30:** Still a patient
7: To state hospital	**05:** To another type of institution
9: To congregate care facility	**04:** To ICF (Intermediate Care Facility)

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) initial claims; and 2) resubmitted claims.

- ***Initial Claims***

  - ✓ MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

    - ➢ The date the provider furnishes the service to the eligible client;
    - ➢ The date a final fair hearing decision is entered that impacts the particular claim;
    - ➢ The date a court orders MAA to cover the services; or
    - ➢ The date DSHS certifies a client eligible under delayed[1] certification criteria.

  - ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

    - ➢ DSHS certification of a client for a retroactive[2] period; or
    - ➢ The provider proves to MAA's satisfaction that there are extenuating circumstances.

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[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- ***Resubmitted Claims***

  Providers may **resubmit, modify, or adjust** any timely initial claim, ***except*** prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the time period listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the time periods described above, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

☞ **Exception:** If billing Medicare Part A crossover claims, bill the amount submitted to Medicare.

How do I bill when a client is admitted and dies on the *same day*?

- If a client is newly admitted and dies on the ***same day***, use Patient Status 20 when billing this claim. This **does not include** when a client is admitted and discharged on the same day.

How do I bill for a client who is discharged in a current month?

When discharging a client from your facility, use the appropriate Patient Status Code and enter the total number of units not including the discharge day.

Will I be paid for the date of discharge if a client is discharged to a hospital?

Nursing facilities are not paid for the date of discharge (keep this in mind when entering total number of units).

How do I bill for Social Leave?

MAA pays for the first 18 days of Social Leave in a year. Report the client as *still a client* for these days. Do not discharge and readmit the client. After 18 days of Social Leave have been used, report discharge and readmit only if the client left the facility for at least a full 24-hour period.

How do I change a previously paid claim?

If you need to make changes to claims for dates of service that MAA has already paid (e.g., because of the change in patient participation, split months, discharge in error), you *must* submit an Adjustment Request (525-109) form [DSHS 13-715] (refer to the Important Contacts section for information on ordering this form). DO NOT REBILL THE PAID CLAIMS. You may submit one adjustment per Internal Control Number (ICN) only.

What is Patient Participation (Form Locator 39.-41.)?

Patient Participation is any amount of funds (e.g., SSA, pensions, Veterans payment) that is treated as income during the eligibility determination. These funds must be contributed toward the patient's cost of care. Enter Patient Participation into form locators 39-41 using value code 31, not into form locator 57.

How do I bill for clients who are eligible for Medicare and Medicaid?

Bill Medicare first. If you bill Medicaid for a class 29 or 24 prior to the Medicare payment, you will automatically receive a $0.00 reimbursement from Medicaid. If money is owed to you on a class 24 claim after Medicare makes payment, you must submit an adjustment form with the appropriate Medicare backup.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claim (see page D.1).

Medicare Part A

Medicare Part A is a health insurance program for:

- Individuals who are 65 years of age and older;
- Certain individuals with disabilities (under 65 years of age); or
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice, and some home health care. Check the client's red, white, and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if they have Medicare Part A coverage. Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

When billing Medicare:

- Indicate *Medical Assistance* and include the patient identification code (PIC) on the claim form as shown on the Medical Identification card. Enter the Medical Assistance provider number.
- Accept assignment.
- If Medicare has allowed the service, in most cases Medicare will forward the claim to MAA. MAA then processes your claim for any supplemental payments.
- If Medicare does not forward your claim to MAA **within 30 days** from its statement date, send the UB-92 claim form and a copy of the Part A Explanation of Medical Benefits (EOMB) to MAA for processing.
- When Part A services are totally disallowed by Medicare but are covered by MAA, bill MAA on the UB-92 claim form and attach copies of Medicare's EOMB with the denial reasons.

☞ **Note:**

- ✓ Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of Medicare's EOMB paid date.
- ✓ A Medicare Remittance Notice or EOMB must be attached to each claim.

Third-Party Liability

You must notify MAA if you know of any third-party liability insurance and the corresponding insurance code is not listed on the Medical ID Card. To report third-party liability, please call Coordination of Benefits at (800) 562-6136. To pursue third-party liability, please contact the liable third party directly.

If you receive payment from a third-party insurance source *after* MAA has made a payment, you must either refund MAA by check or submit an adjustment.

Send checks and a copy of the insurance explanation of benefits to:

Office of Financial Recovery-MED
PO Box 45862
Olympia, WA 98504-5862

If you prefer to send an adjustment using the DSHS Adjustment Request (525-109) form [DSHS 13-715] (refer to the **Important Contacts** section for information on ordering this form), please attach the insurance explanation of benefits and a copy of the MAA Remittance and Status Report showing the original payment to the adjustment request.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains. Keep copies of award letters on hand for auditing purposes when changing patient participation.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, **for at least six years from the date of service** or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. [Refer to WAC 388-502-0020 (2)]

How to Complete the UB-92 Claim Form

Note: These instructions are specific to nursing facilities. *The underlined Form Locator names are required by MAA to process a nursing facility claim.*

Bill only dates of service for which the client is eligible.

FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION:

1. **Provider Name, Address & Telephone Number** - The provider name, address, and telephone number as filed with the MAA Division of Program Support (DPS).

4. **Type of Bill** – Enter:

a. 211 for claims;
b. 217 for adjustments; and
c. 218 for voids.

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - The client's last name, first name, and middle initial as shown on the client's Medical Identification card.

13. **Patient Address** - The client's address.

14. **Patient Birthdate** - The client's birthdate. (MMDDYYYY)

15. **Patient Sex** - The client's sex. (M or F)

17. **Admission Date** - The date of admission. (MMDDYYYY)

18. **Admission HR** – The hour which the patient was admitted for care.

19. **Admission Type**– The type of admission.

20. **Admission SRC** – The source of admission.

21. **Discharge Hour** – The hour during which the patient was discharged from care.

22. **Stat** - Enter a valid Patient Status code to represent the disposition of the patient's status. See page C.2.

32.-35. **Occurrence Code and Date**- The appropriate occurrence code and related date.

36. **Occurrence Span** - The appropriate occurrence code and related dates.

38. Responsible Party Name and Address –The name and address of the party responsible for the bill.

39.-41. Value Codes and Amounts –The following Value Codes are required to process your nursing facility claims:

Value Code 24 – Enter this code in the code field with the Patient Class immediately following in the amount field. See page C.1 for valid Patient Class codes. (e.g., 20.00=class code 20)

Value Code 31 – Enter this code in the code field with the Patient Participation amount for the entire month immediately following in the amount field.

42. Revenue Code - Enter revenue code 0190.

43. Revenue or Procedure Description – The description of the related revenue code. Abbreviations may be used.

44. HCPCS/Rates - Enter nursing facility daily rate.

45. Serv. Date – Same as form locator 6.

46. Units of Service - Enter the number of days. Do not include the date of discharge. See pages D.2 and D.3.

47. Total Charges – Equals the amount in form locator 44 multiplied by the amount in form locator 46.

48. Non-Covered Charges - Any charges not covered by MAA.

50. Payer Identification: A/B/C - All health insurance benefits available.

50A: Enter *Medicaid*.
50B: Enter the name of additional insurance (e.g., Medicare, Aetna, etc.), if applicable.
50C: Enter the name of additional insurance, if applicable.

51. Provider Number - Enter the nursing facility provider number issued to you by MAA. This is the 7-digit provider number beginning with a "4" that appears on your Remittance and Status Report.

54. Prior Payments: A/B/C - The amount due or received from all insurances. **Do not include participation amount here.**

54A: Any prior payments from payor listed in form locator 50A.
54B: Any prior payments from payor listed in form locator 50B.
54C: Any prior payments from payor listed in form locator 50C.

55. Estimated Amount Due: A/B/C –

55A: The estimated amount due from MAA minus any amounts listed in form locators 54 and 39-41.
55B: Not required to be filled in.
55C: Not required to be filled in.

58. **Insured's Name: A/B/C** – The insured's name if other insurance benefits are available and coverage is under another name.

60. **Cert-SSN-HIC-ID NO.** - Enter the Medicaid Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical ID card. This information is obtained from the client's current monthly Medical ID card and consists of the client's:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d. An alpha or numeric character (tiebreaker).

61. **Insurance Group Name** - If other insurance benefits are available, the name of the group or the plan through which insurance is provided to the insured.

62. **Insurance Group Number** - If other insurance benefits are available, any identification number that identifies the group through which the individual is covered.

63. **Treatment Authorization Codes** - The assigned authorization number.

64. **ESC** - The code used to define the employment status of the individual identified in form locator 58.

65. **Employer Name** - If other insurance benefits are available, the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

67. **Principal Diagnosis Code** - The ICD-9-CM diagnosis code describing the principal diagnosis. Not required unless billing with third-party liability.

68.–75. **Other Diag. Codes** – Any additional ICD-9-CM diagnosis codes indicating any other conditions.

76. **ADM. DIAG.CD.** – The ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

80. **Principal Procedure** – The code that identifies the principal procedure performed during the period covered by this bill.

81. **Other Procedure** – The codes identifying all significant procedure(s) other than the principal procedure.

82. **Attending Physician I.D.** - The 7-digit provider identification number issued by MAA. Do not complete this box with a clinic billing number. For attending physicians not enrolled in the Medical Assistance program, enter the name of the attending physician in this form locator.

83. **Other Physician I.D.** - The referring provider number issued by MAA.

84. **Remarks** - Any information applicable to this stay that is not already indicated on the claim form such as extended stay approval.

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
ABC Nursing Home 123 Maple Lane Anywhere, WA 99999 (360) 555-1234			211

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	070105	070105					

12 PATIENT NAME	13 PATIENT ADDRESS
SMITH, John D	123 Maple Lane, Anywhere, WA 99999

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
010130	M							01									

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a											A
b											B
											C

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	24	20.00	31	500.00		
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0190	Room & Board	150.00	070105					1
2				071505	14	2,100.00			2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15				SAMPLE:					15
16				With TPL					16
17									17
18									18
19									19
20									20
21									21
22									22
23		Total Charges				2100.00			23

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR P AYMENTS	55 EST. AMOUNT DUE	56
A	Medicaid	4123456				1750.00	
B	Group Health				350.00		
C							
57		DUE FROM PATIENT ▶					

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GR OUP NAME	62 INSURANCE GR OUP NO.
A	Smith, John A		JA010130SMITH A		
B	Smith, Jane D			Group Health	0123456
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLO YER LOCATION
A				
B			XYZ Administrators	456 Countrv Ct. Yourtown. WA 99998
C				

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
7837											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
C		D		E	

82 ATTENDING PHYS. ID	1234567
	Jane Doe, MD

83 OTHER PHYS. ID	
	A
OTHER PHYS. ID	
	B

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
	X	

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
ABC Nursing Home 123 Maple Lane Anywhere, WA 99999 (360) 555-1234			211

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	070105	070105					

12 PATIENT NAME	13 PATIENT ADDRESS
SMITH, John D	123 Maple Lane, Anywhere, WA 99999

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
010130	M							01									

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a											A
b											B
											C

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT	
a	24	20.00	31	500.00			a
b							b
c							c
d							d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0190	Room & Board	150.00	070105					1
2				071505	14	2,100.00			2
3									3
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7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		Total Charges				2100.00			23

SAMPLE:
No TPL

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR P AYMENTS	55 EST. AMOUNT DUE	56	
Medicaid	4123456				2100.00		A
							B
							C
57	DUE FROM PATIENT ▶						

58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GR OUP NAME	62 INSURANCE GR OUP NO.	
Smith, John A		JA010130SMITH A			A
					B
					C

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLO YER LOCATION	
				A
				B
				C

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	C		D		E	

82 ATTENDING PHYS. ID	1234567
	Jane Doe, MD
83 OTHER PHYS. ID	A
OTHER PHYS. ID	B
85 PROVIDER REPRESENTATIVE	86 DATE
X	

84 REMARKS	
a	
b	
c	
d	

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.